



DEPARTMENT OF SAFETY
DIVISION OF FIRE STANDARDS AND TRAINING &
EMERGENCY MEDICAL SERVICES
NH EMS IMMUNIZATION PREREQUISITE
QUALITY MANAGEMENT
QUARTERLY REPORT FORM
PLEASE PRINT (BLACK INK) OR TYPE



For the Quarter Ending (mm/dd/yyyy): ____/____/____

Unit Name _____ Unit License Number _____

Unit Leader _____ Contact # _____

Medical Resource Hospital _____

Medical Director or Designee _____ Contact # _____

Clinic Site Location _____
Location name

street address _____ city/town _____

Vaccine type _____ Dose _____ Lot # _____

Number of participants _____ Male _____ Female _____ Age range _____ - _____
youngest oldest

Did any patients experience any adverse effects? No _____ Yes _____, **if yes, please explain incident, corrective measures taken and attach documentation.**

Please supply the following:

- _____ Copy of physician order for the clinic
- _____ Copies of Screening Questionnaire (Adult item #P4065 or Child & Teen item #P4060)
- _____ Copies of "Do I Need Any Vaccinations Today" Adults Only (item #P4036)
- _____ Copies of Skills Checklist for Immunization (Adult form IMM-694B 09/01 or Pediatric IMM-694 12/11/00)
- _____ Vaccination Administration Records (Adult Item# P2023 or Children & Teen Item #P2022 05/06)
- _____ Copies of most current CDC Vaccine Information Statement
- _____ List of paramedics who participated in the clinic with their NH Provider License Number.

Please use a separate sheet of paper to provide additional comments:

Please return to:
Vicki Blanchard, ALS Coordinator
NH Department of Safety
Division of Fire Standards and Training and
Emergency Medical Service
33 Hazen Drive
Concord, NH 03055